1

Item 20 Film 242 5-15-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5671

CERTIFICATE OF DEATH

05646

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 3 months
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: USARMY HOSPITAL, ABERDEEN PROVING GROUND, MD

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
d. STREET ADDRESS: 104 B Garden Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROGER — Middle ALLEN — Last ANDERSON

4. DATE OF DEATH: Month May — Day 5 — Year 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug 4, 1936

9. AGE (In years last birthday): 22 yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Soldier - 2d Lt

10b. KIND OF BUSINESS OR INDUSTRY: US Army

11. BIRTHPLACE (State or foreign country): South Dakota

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harvey Willard Anderson

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes
(If yes, give war or dates of service): 1959

16. SOCIAL SECURITY NO.: 504-34-6206

17. INFORMANT — Address: Official Army Records

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Gunshot wound of brain
DUE TO (b): Gunshot wound
DUE TO (c): Skull fracture

976X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

same as a above

INTERVAL BETWEEN ONSET AND DEATH: 17 to 19 hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

2

Suicide

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT ☐ WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Gunshot wound of the head

20c. TIME OF INJURY: 1030 o. m. p. m. — Month May — Day 4 — Year 1959

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Aberdeen (County) Harford (State) Maryland

21. I certify that I attended the deceased from 1225 May 4, 1959, to 5:30 May 5, 1959, that I last saw the deceased alive on 3:30 May 5, 1959, and that death occurred at 5:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Lawrence R Ward M.D.

ADDRESS (Street, city or town, state): US Army Hospital Aberdeen Proving Gd Md

DATE SIGNED: 5 May 59

PHYSICIAN'S NAME (Type): LAWRENCE R WARD, CAPT

22a. BURIAL, CREMATION, REMOVAL (Specify): REMOVAL

22b. DATE THEREOF: 5-7-59

22c. NAME OF CEMETERY OR CREMATORY: YANKTON

22d. LOCATION (City, town, or county) (State): YANKTON, SOUTH DAKOTA

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Wm Cook-Blight, Inc. 6009 Harford Road

24a. REC'D BY REGISTRAR — DATE: MAY 12 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5632 CERTIFICATE OF DEATH

05647

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 15 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Dallam Place

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Bel Air
d. STREET ADDRESS: 1 Dallam Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: ; Last: Ayres

4. DATE OF DEATH: Month: May; Day: 30; Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec. 6, 1876

9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Housework

11. BIRTHPLACE (State or foreign country): Harford Co., Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Joseph Mc Kee

14. MOTHER'S MAIDEN NAME: --- Wann

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Mary C. Ayres — Address: Dallam Place, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 24 Hrs.
4221
DUE TO
Conditions, if any, which gove rise to immediate couse (a), stoting the underlying cause last.
(b): Chr. Caddio-Vascular Disease — 10 yrs.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 2, 1953, to May 30, 1959, that I last saw the deceased alive on May 30, 1959, and that death occurred at 6:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Md. — DATE SIGNED: May 30, 1959

PHYSICIAN'S NAME (Type): Willard P. Hudson M.D. — Forest Hill, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: June 3, 1959

22c. NAME OF CEMETERY OR CREMATORY: St. Ignatius

22d. LOCATION (City, town, or county) (State): Hickory, Harford Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph W. Foster — ADDRESS: W. Broadway + Williams St. Bel Air, Maryland

24a. REC'D BY REGISTRAR DATE: JUN 2 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [redacted]ral director, page 3 should be d[redacted]ed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 sha[redacted]e filed with the registrar priar to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5672 CERTIFICATE OF DEATH

Reg. Dist. No. 05648

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Norrisville
c. LENGTH OF STAY IN 1b: 2 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Norrisville
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Nicholas Middle N. Last Ayres
4. DATE OF DEATH: Month May Day 9 Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Dec. 24, 1876
9. AGE (In years last birthday): 82 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer retired
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Shawsville, Md.
12. CITIZEN OF WHAT COUNTRY?: U. S. A.
13. FATHER'S NAME: Thomas Ayres
14. MOTHER'S MAIDEN NAME: Alice Ann Norris
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: 205-22-3834A
17. INFORMANT: Arnold Ayres Address: Fawn Grove, Pa.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Chronic myocarditis, Ca. prostate — INTERVAL BETWEEN ONSET AND DEATH
422.1
DUE TO (b): due to infiltration of Pelvic age.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): generalized arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES [ ] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 19, 19 58, to May 9, 19 59, that I last saw the deceased alive on May 7, 19 59, and that death occurred at 12:30 P. M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Norman H. Gemmill M.D. ADDRESS (Street, city or town, state): Stewartstown, Pa. DATE SIGNED: May 9, 1959.
PHYSICIAN'S NAME (Type): Norman H. Gemmill

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/11/1959
22c. NAME OF CEMETERY OR CREMATORY: Ayres Chapel
22d. LOCATION (City, town, or county) (State): White Hall, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Hurt ADDRESS: Jarrettsville, Md.
24a. REC'D BY REGISTRAR DATE: MAY 12 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05649

3653 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 5 mos.,
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 Bel Air
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Grace — Middle: L. — Last: Bowers

4. DATE OF DEATH: Month: May — Day: 9 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 13, 1916

9. AGE (In years last birthday): 42 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): none

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY?: U.S.A.,

13. FATHER'S NAME: Guy M. Taylor

14. MOTHER'S MAIDEN NAME: Gertrude S. Brown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: ?

17. INFORMANT — Address: Ruth P. Taylor, Bel Air, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIO-RESP. FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 DAYS
170X
DUE TO
(b): METASTATIC CARCINOMA. — 4 Yrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c): CARCINOMA OF BREAST — 2 yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 23 MARCH, 1959, to 9 MAY, 1959, that I last saw the deceased alive on 5 MAY, 1959, and that death occurred at 3:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: H P Sidwell M.D.
ADDRESS (Street, city or town, state): 401 Franklin St. Bel Air Md
DATE SIGNED: May 59

PHYSICIAN'S NAME (Type): H.P. Sidwell
401 Franklin St., Bel Air, Maryland.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May, 12, 1959
22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial Gardens
22d. LOCATION (City, town, or county) (State): Bel Air, Harford, Md.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard L McComas Jr
ADDRESS: Abingdon, Maryland.

24a. REC'D BY REGISTRAR DATE: MAY 14 '59
24b. REGISTRAR'S SIGNATURE: Arthur L Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

5654

05650 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 21 HRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
d. STREET ADDRESS: 616 LEWIS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: BABY Middle: Boy Last: BRENDLE

4. DATE OF DEATH: Month: MAY Day: 7 Year: 1959

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: MAY 6 1959

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months — Days; IF UNDER 24 HRS.: Hours 20 Min. 54

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Wm K. BRENDLE

14. MOTHER'S MAIDEN NAME: Evelyn Jane Smith

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): — (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Dr. Wm K. BRENDLE, Address: HAVRE DE GRACE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): RESPIRATORY FAILURE DUE TO PULMONARY — INTERVAL BETWEEN ONSET AND DEATH: 8 hrs -
DUE TO
(b): HYALINE MEMBRANE DISEASE
DUE TO
(c): PREMATURITY (WEIGHT 5# 5½ oz)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6 May, 1959, to 7 May, 1959, that I last saw the deceased alive on 7 May, 1959, and that death occurred at 2:25 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: [signature] M.D. — ADDRESS (Street, city or town, state): 602 S. Union Ave Havre de Grace Md — DATE SIGNED

PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5-9-1959

22c. NAME OF CEMETERY OR CREMATORY: ANGEL HILL Cem

22d. LOCATION (City, town, or county) (State): HAVRE DE GRACE MD

23. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE: MAY 14 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

2071353XV3

1 5

Item 18, 19 Film 243 5/21/59 ams

5673

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item9 FilmG243 5/21/59 cap

05651

Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: HARFORD
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air, Md.
c. LENGTH OF STAY IN 1b: 2
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Havre de Grace
d. STREET ADDRESS: Alliance
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FATE Middle — Last BROWN

4. DATE OF DEATH: Month 5 Day 9 Year 1959

5. SEX: M

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/10/1920

9. AGE (In years last birthday): 39 YRS.
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS.: Hours — Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): Hawkinsville Ga.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: 2 Brown

14. MOTHER'S MAIDEN NAME: Carrie Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): W.W. 2

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: James Hill 43.4½ W. Broad Savanah. Ga.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
INTERVAL BETWEEN ONSET AND DEATH:

491X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — o. m. p. m. — Month, Day, Year — 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Paul F. Guerin M.D.

EXAMINER'S NAME (Type): PAUL F. GUERIN

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: 5-10-59

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5/17/59

22c. NAME OF CEMETERY OR CREMATORY: Sylvester

22d. LOCATION (City, town, or county) (State): Sylvester Ga.

23. FUNERAL DIRECTOR'S SIGNATURE: Pennington Bros

ADDRESS: Havre de Grace. Md

24a. REC'D BY REGISTRAR DATE: MAY 18 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5674

Item 1 FilmG243 5/27/59 cap

05652

CERTIFICATE OF DEATH

Reg. Dist. No.....

1. PLACE OF DEATH

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Bel Air

LENGTH OF STAY (in this place) 12 days

HOSPITAL OR INSTITUTION OR STREET ADDRESS Private Home Graftons Road, Churchville

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X rural Jarrettsville

STREET ADDRESS (If rural give location) Rocks, RD

3. NAME OF DECEASED (Type or Print) (First) Maudie (Middle) Elizabeth (Last) Brown

4. DATE OF DEATH (Month) May (Day) 16, (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Married	Aug. 22, 1890	68 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Housewife	Home	Renick, W. Va.	U. S. A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Harvey Brown	Fannie Boggs

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	----	233-34- 5252	Isaac M. Brown Rocks, Maryland

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
443X IMMEDIATE CAUSE	(A)	Cerebral Vascular Accident	24 days
ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.	DUE TO (B)	Hypertensive C-V-D	20 years
	DUE TO (C)		

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☐

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/28/50, 19..... to 5/16/59, 19....., that I last saw the deceased alive on 5/16/59, 19....., and that death occurred at 7:30 AM, from the causes and on the date stated above.

SIGNATURE Robert Burton M.D. **ADDRESS** (Street, city, town, state) Forest Hill, Maryland **DATE SIGNED** 5/16/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/21/1959	Bel Air Memorial Gardens	Bel Air, Maryland

24. REC'D BY REGISTRAR DATE MAY 19 '59	REGISTRAR'S SIGNATURE Orlan S. Krause	25. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz	ADDRESS Jarrettsville Md.

1

FOR STATE HEALTH DEPT.

M

X

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5675

05653
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Edgewood
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) MS Rute 40 40

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Md
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen
d. STREET ADDRESS Custer St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Judy Middle: G. Last: Burgess

4. DATE OF DEATH Month: May Day: 30 Year: 1959

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Aug. 10, 1938
9. AGE (In years last birthday): 20 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk-Steno.,
10b. KIND OF BUSINESS OR INDUSTRY: U.S. Govt.,
11. BIRTHPLACE (State or foreign country): Maine
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William R. Burgess
14. MOTHER'S MAIDEN NAME: Josephine Lynch

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 007-38-6702
17. INFORMANT: William R. Burgess, Address: Sanford, Maine.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture skull
816X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident - car with tractor-trailer
20c. TIME OF INJURY Hour: 1215 o. m. p. m. Month, Day, Year: 5-30 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): MS Rute 40
20f. (City or town) Joppa (County) Harford (State) Md.

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D. CHIEF MEDICAL EXAMINER ☐ Bel Air, Md DATE SIGNED
EXAMINER'S NAME (Type) Gerald C Palmer M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ 5-30-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: June, 3, 1959
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or county) (State): Arlington, Fairfax, Virginia.

23. FUNERAL DIRECTOR'S SIGNATURE: Howard K. McComas Jr
ADDRESS: Abingdon, Maryland.
24a. REC'D BY REGISTRAR DATE JUN 2 '59
24b. REGISTRAR'S SIGNATURE: Catherine S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05654

5655 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b: 1 month
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Convalescent Home

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Rural Bel Air
d. STREET ADDRESS: Wheel Rd., Rt. # 2, Bel Air, Md.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First Ennice — Middle — Last Cheek
4. DATE OF DEATH: Month May — Day 25 — Year 1959
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]
8. DATE OF BIRTH: Oct. 28, 1873
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY?: U.S.A.
13. FATHER'S NAME: Ashley Cheek
14. MOTHER'S MAIDEN NAME: Ada Johnson
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: none
17. INFORMANT — Address: Mr. Cecil Cheek, Wheel Rd., Rt. # 1, Bel Air, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Lobar Pneumonia, terminating	5 days
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO		
(c)	Chronic hypertensive cardio-vascular disease	15 years

443X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED: While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1939, to May 25, 1959, that I last saw the deceased alive on May 25, 1959, and that death occurred at 10:35 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D.
ADDRESS (Street, city or town, state): Forest Hill, Md.
DATE SIGNED: May 25, 1959
PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May, 27, 1959
22c. NAME OF CEMETERY OR CREMATORY: Mt., Carmel
22d. LOCATION (City, town, or county) (State): Emmorton, Harford, Md.,

23. FUNERAL DIRECTOR'S SIGNATURE: Howard L. McComas Jr.
ADDRESS: Abingdon, Md.,
24a. REC'D BY REGISTRAR — DATE: JUN 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [redacted] director, page 3 should be [redacted] for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5656

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05655
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BEL AIR
c. LENGTH OF STAY IN 1b: 2 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 12 LANGFORD PLACE

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 32 BEL AIR
d. STREET ADDRESS: 12 LANGFORD PLACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First THEODORE — Middle EUGENE — Last CORNELL
4. DATE OF DEATH: Month MAY — Day 16 — Year 1959

5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG 12, 1907
9. AGE (In years last birthday): 51 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HR.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NAT. GAS
10b. KIND OF BUSINESS OR INDUSTRY: GAS LINES
11. BIRTHPLACE (State or foreign country): WEST VA.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: LAFAYETTE CORNELL
14. MOTHER'S MAIDEN NAME: NANCY PETHTEL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 233-16-5072
17. INFORMANT: Address: MRS ORA CORNELL 12 LANGFORD, BEL AIR

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 15 MIN
420.1
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. / p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W. Heuman M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: MAY 16, 1959
EXAMINER'S NAME (Type): PHILIP W. HEUMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: May 19, 1959
22c. NAME OF CEMETERY OR CREMATORY: Willow Island
22d. LOCATION (City, town, or county): Waverly (State): W. Va

23. FUNERAL DIRECTOR'S SIGNATURE: Joseph T. Foster
ADDRESS: Belair Md

24a. REC'D BY REGISTRAR DATE: MAY 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur E. Krous

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 Film 6257, 2-24-60 JF

05656

5657 **CERTIFICATE OF DEATH**

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] director, page 3 should be completed for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: Harford	MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Maryland	b. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air	c. LENGTH OF STAY IN 1b: 7 Years	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Almshouse- Harford County		d. STREET ADDRESS: ALMSHOUSE - HARFORD, CO.	e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Margaret Elizabeth	LEE	Curry	May	30	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	White		Oct. 20, 1871	87 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
HOUSE WIFE	RETIRED	MD	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
John Wright	Martha Crew

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT Address
No	—	—	SAMUEL G. CURRY, HAVRE DE GRACE, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Coronary occlusion	Sudden
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Chr. Cardio-Vascular Disease	?
DUE TO (c)		

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 1952, 19____, to May 1959, 19____, that I last saw the deceased alive on May 29, 1959, 19____, and that death occurred at 2 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): [illegible] — DATE SIGNED: 5/30/59

PHYSICIAN'S NAME (Type): Willard P. Hudson M.D. — Forest Hill, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	6-1-1959	ROCK RUN CEM.	HARFORD MD.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	24a. REC'D BY REGISTRAR DATE	24b. REGISTRAR'S SIGNATURE
R Madison Mitchell Havre de Grace, Md.	JUN 3 '59	Clifton S. Evans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5658 CERTIFICATE OF DEATH

05657
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace R.D. 1
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X
d. STREET ADDRESS /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Lillie Middle M. Lost Edwards

4. DATE OF DEATH Month May Day 22 Year 1959

5. SEX Female

6. COLOR OR RACE White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Jan 21 1871

9. AGE (In years last birthday) 88 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework at home

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Harford Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME James H. Bowman

14. MOTHER'S MAIDEN NAME Elizabeth Sheridan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 212-14-1498B

17. INFORMANT Address Mrs. M. Edwards Havre De Grace Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.1

DUE TO (b) Myocarditis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Arteriosclerosis

INTERVAL BETWEEN ONSET AND DEATH (a) 1 Md (b) 7 Yr (c) 3 Yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) ✓

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 4, 1959 to May 22, 1959, that I last saw the deceased alive on May 22, 1959, and that death occurred at 4 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE F P Snodgrass M.D. ADDRESS (Street, city or town, state) Darlington Md DATE SIGNED 5/23/59

PHYSICIAN'S NAME (Type) F. P. Snodgrass

22a. BURIAL, ~~CREMATION~~, REMOVAL (Specify) 22b. DATE THEREOF May 25, 1959

22c. NAME OF CEMETERY OR CREMATORY Rock Run

22d. LOCATION (City, town, or county) (State) Harford Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey ADDRESS Darlington Md

24a. REC'D BY REGISTRAR DATE MAY 28 '59

24b. REGISTRAR'S SIGNATURE Carlton L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item9 FilmG244 7/16/59 cap

5659

CERTIFICATE OF DEATH

Reg. Dist. No. 05658

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 1 Hr. 55 min.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD Memorial Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE 24
d. STREET ADDRESS: 952 CHESAPEAKE DR.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY — Middle — Last GRILLE

4. DATE OF DEATH: Month MAY — Day 2 — Year 1959

5. SEX: FEMALE
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7/14/1914
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FEDERAL Employee
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): MARYland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE BAEKEY
14. MOTHER'S MAIDEN NAME: NELLIE Boyd

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: Mrs Nellie Baekey 952 Chesapeake Drive — Address Havre de Grace Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 3 DAYS
DUE TO
(b): ARTERIOSCLEROSIS — YEARS
420.1
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4/29, 1959, to 5/2, 1959, that I last saw the deceased alive on 5/2, 1959, and that death occurred at 10:55 P M, from the couses and on the date stated above.

ACTUAL SIGNATURE: Irwin Randall Ross M.D. — ADDRESS (Street, city or town, state): 209 N. Union Ave — DATE SIGNED
PHYSICIAN'S NAME (Type): IRWIN RANDALL ROSS — Havre de Grace, Md.

22a. (BURIAL) CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/7/59
22c. NAME OF CEMETERY OR CREMATORY: Angel Hill
22d. LOCATION (City, town, or county) (State): Havre de Grace Md

23. FUNERAL DIRECTOR'S SIGNATURE: Thomas Lee Lam — ADDRESS: Havre de Grace Md
24a. REC'D BY REGISTRAR DATE: MAY 7 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5676

05659

Reg. Dist. No.

FOR STATE HEALTH DEPT. USE

1

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN [If outside corporate limits, write RURAL and give nearest town]: ROCKS (RURAL)
c. LENGTH OF STAY IN 1b: 3 MONTHS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address): SHARON Rd

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD. — b. COUNTY: HARFORD.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × ROCKS (RURAL)
d. STREET ADDRESS: SHARON RD.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First ALFRED — Middle ANDREW — Last GUNTENSPERGER
4. DATE OF DEATH: Month MAY — Day 6 — Year 19 59

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 10, 1916
9. AGE [In years last birthday]: 43 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): MACHINIST
10b. KIND OF BUSINESS OR INDUSTRY: EDGEWOOD ARSENAL
11. BIRTHPLACE (State or foreign country): BALTIMORE, MD.
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: ALFRED J. GUNTENSPERGER.
14. MOTHER'S MAIDEN NAME: MARY D. ROTH.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): YES (If yes, give war or dates of service): W.W II
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: MARY GUNTENSPERGER SAME.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY THROMBOSIS — INTERVAL BETWEEN ONSET AND DEATH: 1½ hours
420.1
DUE TO (b): NONE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour o. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Philip W. Heuman M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: MAY 6, 1959
EXAMINER'S NAME (Type): PHILIP W. HEUMAN

22a. BURIAL, CREMATION, REMOVAL (Specify): CREMATION
22b. DATE THEREOF: 5-9-59
22c. NAME OF CEMETERY OR CREMATORY: GREENMOUNT CEM.
22d. LOCATION (City, town, or county) (State): Balto. Md

23. FUNERAL DIRECTOR'S SIGNATURE: Charles L. Zeiler
ADDRESS: 901 S. CONKLING ST. BALTO., 24, MD.
24a. REC'D BY REGISTRAR — DATE: MAY 8 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05660

5677

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md — b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Darlington — c. LENGTH OF STAY IN 1b: Life

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): x Darlington

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

d. STREET ADDRESS:

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Anna — Middle: D — Last: Hopkins

4. DATE OF DEATH: Month: May — Day: 16 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 25, 1878

9. AGE (In years last birthday): 80 yrs.

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House work at Home

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Harford Co Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Francis A Hopkins

14. MOTHER'S MAIDEN NAME: Angie E Harper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unknown): No

(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: No

17. INFORMANT: Miss Isabelle Brown — Address: Darlington Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Old Age — INTERVAL BETWEEN ONSET AND DEATH:
794x
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 14, 1947, to May 16, 1959, that I last saw the deceased alive on May 12, 1959, and that death occurred at 9:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Dudley Phillips M.D. — ADDRESS (Street, city or town, state): Darlington Md — DATE SIGNED: 5/20/59

PHYSICIAN'S NAME (Type): Dudley Phillips — Darlington Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: May 19, 1959 — 22c. NAME OF CEMETERY OR CREMATORY: Darlington Cem — 22d. LOCATION (City, town, or county): Harford Co. (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE: H S Bailey — ADDRESS: Darlington Md

24a. REC'D BY REGISTRAR — DATE: MAY 28 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5660 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 05661

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace
c. LENGTH OF STAY IN 1b 61 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Revolution St

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 24 Havre de Grace
d. STREET ADDRESS 111 N. Stokes St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First George Middle Warren Last Hughes

4. DATE OF DEATH Month May Day 28 Year 1959

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2/13/1897
9. AGE (In years last birthday) 62 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage
10b. KIND OF BUSINESS OR INDUSTRY Self
11. BIRTHPLACE (State or foreign country) Havre de Grace
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME George W. Hughes Sr
14. MOTHER'S MAIDEN NAME Laura Anthony

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown
16. SOCIAL SECURITY NO. Unknown
17. INFORMANT Address Mrs. Geo. W. Hughes 111 N. Stokes St Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH

420.1

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Baltimore Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5-29-59

EXAMINER'S NAME (Type) Gerald E Palmer MD

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF 5/31/59
22c. NAME OF CEMETERY OR CREMATORY Angel Hill
22d. LOCATION (City, town, or county) Havre de Grace (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE Cunningham Bros, ADDRESS Havre de Grace Md.

24a. REC'D BY REGISTRAR DATE JUN 3 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5678 CERTIFICATE OF DEATH

05662
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 133 Post Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen
d. STREET ADDRESS: 133 Post Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEWIS — Middle HENRY — Last MARTIN

4. DATE OF DEATH: Month May — Day 18 — Year 19 59

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept. 9, 1883

9. AGE (In years last birthday): 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Freight Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Railroad

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: George Chapman Martin

14. MOTHER'S MAIDEN NAME: Cornelia Slee

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. L.H. Martin, Address 133 Post Rd. Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1 Myocardial Infarction — INTERVAL BETWEEN ~~ONSET~~ AND DEATH: Termina
DUE TO
(b): Coronary Occlusion — Terminal
DUE TO
(c): Coronary arteriosclerosis — 2 yr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 1953, 19__, to 5-18-1959, that I last saw the deceased alive on 5/15/59, 19__, and that death occurred at 12:30 A.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Peter P. Rodman, M.D.
ADDRESS (Street, city or town, state): 8 Law Street
DATE SIGNED: 5-18-59

PHYSICIAN'S NAME (Type): Peter P. Rodman, M.D. — Aberdeen, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/20/59
22c. NAME OF CEMETERY OR CREMATORY: Spesutia Cemetery
22d. LOCATION (City, town, or county) (State): Perryman, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John L. Tarring
ADDRESS: Tarring Funeral Home Aberdeen, Md.

24a. REC'D BY REGISTRAR DATE: MAY 20 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Frazer

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5661 CERTIFICATE OF DEATH

Reg. Dist. No. 05663

1. PLACE OF DEATH
a. COUNTY Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre-de-Grace
c. LENGTH OF STAY IN 1b 4 days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Pa
b. COUNTY York
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hanover R. 75x-3
d. STREET ADDRESS R.D #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Ira Middle Cleveland Last Masemer

4. DATE OF DEATH Month 5 Day 6 Year 1959.

5. SEX Male
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Jan 30. 1885
9. AGE (In years last birthday) 74 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman.
10b. KIND OF BUSINESS OR INDUSTRY Dupker City Paper Co.
11. BIRTHPLACE (State or foreign country) Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Masemer, Eli.
14. MOTHER'S MAIDEN NAME Ramer, [redacted] IDA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No. (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 176-01-1107
17. INFORMANT Address Melvin Masemer, York, Pa. 6 Summit R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH 1 day
331 X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 5/2, 19 59, to 5/6, 19 59, that I last saw the deceased alive on 5/6, 19 59, and that death occurred at 7.20 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE Dudley Phillips M.D. ADDRESS (Street, city or town, state) Dudley Phillips DATE SIGNED 5/7/59
PHYSICIAN'S NAME (Type) DARLington md Darlington md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 5/10/59
22c. NAME OF CEMETERY OR ~~CREMATORY~~ Mummerts Church Cem.
22d. LOCATION (City, town, or county) (State) East Berlin Adamstn Pa.

23. FUNERAL DIRECTOR'S SIGNATURE Edward L. Baumeister ADDRESS York, Pa.
24a. REC'D BY REGISTRAR DATE MAY 11 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5662 CERTIFICATE OF DEATH

Reg. Dist. No. 05664

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 6 Days
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: HARFORD Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X FOREST Hill.
d. STREET ADDRESS: 1
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: VIRGINIA Middle: MAE Last: PATRICK

4. DATE OF DEATH: Month: MAY Day: 19 Year: 19 59

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Sept 14 1897

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN C. McGRAW

14. MOTHER'S MAIDEN NAME: NORA BOGGS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 220-14-7938

17. INFORMANT: Lonnie Patrick Address: Forest Hill. Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anteroseptal Infarction — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO
(b): Coronary thrombosis — 4 days
DUE TO
(c): Arteriosclerotic Cardiovascular Disease — 5yrs.

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 12th 19 59, to May 19 19 59, that I last saw the deceased alive on May 19th 19 59, and that death occurred at 1.35 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward C. Foo M.D. — ADDRESS (Street, city or town, state): 210 N. Union Ave. — DATE SIGNED: 5/19/59

PHYSICIAN'S NAME (Type): Edward C. Foo, M.D. Havre de Grace, Md. 1 P.M.

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: May 22, 1959

22c. NAME OF CEMETERY OR CREMATORY: Dublin Cem

22d. LOCATION (City, town, or county): Harford Co (State): Md

23. FUNERAL DIRECTOR'S SIGNATURE: H. S. Bailey — ADDRESS: Darlington Md

24a. REC'D BY REGISTRAR DATE: MAY 22 '59

24b. REGISTRAR'S SIGNATURE: Cecilia E. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05665

5663 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH — a. COUNTY: Harford — b. STATE: Maryland — b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace Md. — c. LENGTH OF STAY IN 1b: 20 yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: —

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — b. COUNTY: Harford — c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace 24 — d. STREET ADDRESS: 900 S. Market — e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First Jessie Middle Jackson Last Poist

4. DATE OF DEATH: Month 5 Day 12 Year 59

5. SEX: Female

6. COLOR OR RACE: White

MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8/16/1884

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: none

11. BIRTHPLACE (State or foreign country): Port Deposit, Md.

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Wesley Jackson

14. MOTHER'S MAIDEN NAME: Nora Woodrow

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Chas. S. Poist — Address: 900 S. Market St. Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL VASCULAR ACCIDENT — INTERVAL BETWEEN ONSET AND DEATH: 5 MIN.
331X
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): ARTERIOSCLEROSIS — YEARS.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) — 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month Day Year 19 — 20d. INJURY OCCURRED While at work ☐ Not while at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I **certify** that I attended the deceased from 1/14, 19 57, to 5/12, 19 59, that I last saw the deceased alive on 5/11, 19 59, and that death occurred at 11:05 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Irwin Randall Ross M.D. — ADDRESS (Street, city or town, state): 200 N. Union Ave — DATE SIGNED

PHYSICIAN'S NAME (Type): IRWIN RANDALL ROSS — Havre de Grace, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): — 22b. DATE THEREOF: 5/15/59 — 22c. NAME OF CEMETERY OR CREMATORY: Mt. Erin — 22d. LOCATION (City, town, or county) (State): Havre de Grace Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Cunningham & Kay — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: MAY 18 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

VS A15 (4)
15M 10/57

5679

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

05666

Reg. Dist. No.

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY: Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa

LENGTH OF STAY (In this place): 10 yrs.,

HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE: Maryland — COUNTY: Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Joppa

STREET ADDRESS (If rural give location):

3. NAME OF DECEASED (Type or Print): (First) Henry (Middle) Basye (Last) Read

4. DATE OF DEATH (Month) May (Day) 21, (Year) 19 59

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months / Days	IF UNDER 24 HRS. Hours / Min.
Male	White	married	Aug. 31, 1886	72 yrs.		

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Stationary Fireman	U.S. Govt.,	Virginia	U.S.A.,

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Thomas Read	Emma Payne

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no		228-18-4867	Thomas H. Read, Rosedale, Maryland.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

151X IMMEDIATE CAUSE (A) Gastric hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)

DUE TO (C) Carcinoma of the stomach — 8 months 1

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☒

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from March 23, 19 59, to May 21, 1959, that I last saw the deceased alive on May 20, 19 59, and that death occurred at 1:12 PM, from the causes and on the date stated above.

SIGNATURE, MD: Willard P. Hudson — ADDRESS (Street, city, town, state): Forest Hill, Maryland — DATE SIGNED: May 22, 1959

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 24, 1959	Bel Air Memorial Gardens	Bel Air, Harford, Maryland.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE	ADDRESS
MAY 26 '59	Arthur S. Krauss	Howard K. McComas Jr.	Abingdon, Md

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 16

CERTIFICATE OF DEATH

Harford | MARYLAND | Harford

Joppa | 10 yrs. | Joppa

Married | Aug. 31, 1886 | Te

Stationary Fireman | U.S. Govt. | Virginia | U.S.A.

Thomas Reed | Jane Payne

No | 228-18-4867 | Thomas H. Reed, Rosedale, Maryland.

Burial | May, 29, 1950 | Bel Air Memorial Gardens | Bel Air, Harford, Maryland.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5664 CERTIFICATE OF DEATH

05667
Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the [illegible] general director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH a. COUNTY: HARFORD — MARYLAND	2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE: Md b. COUNTY: Harford
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre de Grace — c. LENGTH OF STAY IN 1b: 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Forest Hill
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial	d. STREET ADDRESS — e. IS RESIDENCE ON A FARM? YES ☐ NO ☐
3. NAME OF DECEASED (Type or print): First: Letcher — Middle: Alexander — Last: Richardson	4. DATE OF DEATH: Month: May — Day: 17 — Year: 1959
5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ — 8. DATE OF BIRTH: Nov 28-1881 — 9. AGE (In years last birthday): 77 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer — 10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country): Virginia — 12. CITIZEN OF WHAT COUNTRY?: U.S.
13. FATHER'S NAME: John Richardson	14. MOTHER'S MAIDEN NAME: Peggy Moxley
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ✓ (If yes, give war or dates of service) — 16. SOCIAL SECURITY NO. ✓	17. INFORMANT: Thomas C Richardson — Address: Bel Air Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 3 days

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b):

DUE TO (c): Chronic Cardio-vascular Disease — ?

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)

21. **I certify** that I attended the deceased from May 12, 1959, to May 17, 1959, that I last saw the deceased alive on May 17, 1959, and that death occurred at 10:30 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Willard P. Hudson M.D. — ADDRESS (Street, city or town, state): Forest Hill, Maryland — DATE SIGNED: May 18, 1959

PHYSICIAN'S NAME (Type): Willard P. Hudson, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial	22b. DATE THEREOF: May 19-1959	22c. NAME OF CEMETERY OR CREMATORY: Bel Air Memorial	22d. LOCATION (City, town, or county) (State): Bel Air Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE: Joseph T Foster — ADDRESS: Bel Air Md	24a. REC'D BY REGISTRAR DATE: MAY 19 '59	24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5665 CERTIFICATE OF DEATH

05668

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE de GRACE
c. LENGTH OF STAY IN 1b: 45 hrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSPITAL

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: HARFORD
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHESAPEAKE DRIVE
d. STREET ADDRESS: HAVRE de GRACE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First HOWARD — Middle GRANT — Last SHAFER

4. DATE OF DEATH: Month MAY — Day 5 — Year 1959

5. SEX: MALE

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: APR. 8, 1898

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): BUSINESS MAN

10b. KIND OF BUSINESS OR INDUSTRY: HOME APPLIANCE

11. BIRTHPLACE (State or foreign country): PENNA

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: CHARLES T. SHAFER

14. MOTHER'S MAIDEN NAME: CORA WHITMER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 178-10-9446

17. INFORMANT: Mrs. PEARL M. Shafer — Address: Havre de Grace, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac Decompensation — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Old rheumatic heart disease — 40 yrs.
DUE TO (c): and Arteriosclerotic Cardio-Vascular Disease

422.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour — o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb. 8th 1954 to May 5th, 1959, that I last saw the deceased alive on May 5th, 1959, and that death occurred at 9:20 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Edward C. Loo, M.D. — ADDRESS (Street, city or town, state): Havre de Grace, Md. — DATE SIGNED: 5/5/59

PHYSICIAN'S NAME (Type): Edward C. Loo, M.D. at 11:30 A.M.

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 5-8-1959

22c. NAME OF CEMETERY OR CREMATORY: BEL AIR MEMORIAL GARDEN

22d. LOCATION (City, town, or county) (State): HARFORD Co. MD

23. FUNERAL DIRECTOR'S SIGNATURE: R. Madison Mitchell — ADDRESS: Havre de Grace, Md.

24a. REC'D BY REGISTRAR DATE: MAY 8 '59

24b. REGISTRAR'S SIGNATURE: Evelyn S. Kruse

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5680 CERTIFICATE OF DEATH

05669
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b: 6 months
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: U.S. Army Hospital Aberdeen Proving Ground, Maryland

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen
d. STREET ADDRESS: 7 Grant Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First SUZAN; Middle DANIESE; Last SHAFFER

4. DATE OF DEATH: Month May; Day 10; Year 19 59

5. SEX: Female

6. COLOR OR RACE: Cau

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 15, 1958

9. AGE (In years last birthday) yrs.: IF UNDER 1 YEAR Months 6; Days; IF UNDER 24 HRS. Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant

10b. KIND OF BUSINESS OR INDUSTRY: Infant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Robert Joseph Shaffer

14. MOTHER'S MAIDEN NAME: Georgenia Erickson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mother — Address: 7 Grant Street Aberdeen, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Increased intracranial pressure.
752X
DUE TO
(b): Congenital hydrocephalus.
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 9, 19 59, to May 10, 19 59, that I last saw the deceased alive on May 10, 19 59, and that death occurred at 6 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. B. Bryant Jr M.D.
ADDRESS (Street, city or town, state):
DATE SIGNED: 5/11/59

PHYSICIAN'S NAME (Type): J. B. BRYANT, JR., MAJOR, MC — USAH, APG, Md. — Busti, Chautauqua Co.

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 5/11/1959
22c. NAME OF CEMETERY OR CREMATORY: Busti Cemetery
22d. LOCATION (City, town, or county) (State): Jamestown New York

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Barring
ADDRESS: Aberdeen Md.

24a. REC'D BY REGISTRAR DATE: MAY 18 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

2050275 X V 4

1

FOR STATE HEALTH DEPT.

5681

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05670
Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Harford
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): P O Box #171

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen
d. STREET ADDRESS: P.O. Box #171
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Kristie Middle Lynn Last Shivers
4. DATE OF DEATH: Month May Day 27 Year 19 59
5. SEX: F
6. COLOR OR RACE: C
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan 10 1959
9. AGE (In years last birthday): — yrs.
IF UNDER 1 YEAR: Months 4 Days 17
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Infant
10b. KIND OF BUSINESS OR INDUSTRY: Infant
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Frank Allan Shivers
14. MOTHER'S MAIDEN NAME: Elsie Mae Murray
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: —
17. INFORMANT: Father: Address: P.O. Box 171 Aberdeen Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: —
493X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D.
CHIEF MEDICAL EXAMINER ☐ Bel Air Md
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 5-27-59
EXAMINER'S NAME (Type): Gerald C Palmer M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/29/1959
22c. NAME OF CEMETERY OR CREMATORY: Mt Calvary Cemetery
22d. LOCATION (City, town, or county) (State): Aberdeen Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Garvin ADDRESS: Aberdeen Md.
24a. REC'D BY REGISTRAR DATE: JUN 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

9 V V V V V V X V V

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5682

05671
Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bel Air
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): N S Route 1

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Street
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Donald Middle Franklin Last Smith
4. DATE OF DEATH: Month May Day 23 Year 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Dec 18 1933
9. AGE (Last birthday): 25 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Test Driver
10b. KIND OF BUSINESS OR INDUSTRY: Aberdeen P.G.
11. BIRTHPLACE (State or foreign country): Scarborough Md
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Vernon F Smith
14. MOTHER'S MAIDEN NAME: Beulah Cullum

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes Navy
16. SOCIAL SECURITY NO.: 212-32-6244
17. INFORMANT: Anna Lee Smith Address: Street Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ① Fracture Cervicle Vertebra
DUE TO: ② Fracture L. femur
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.): Auto accident auto motorcycle Type
20c. TIME OF INJURY: Hour 5 p.m. Month, Day, Year 5-23 1959
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): N S Route 1
20f. (City or town) Bel Air (County) Harford (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Gerald C Palmer M.D. CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): Gerald C Palmer MD
Bel Air Md
DATE SIGNED: 5-23-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 5/26/1959
22c. NAME OF CEMETERY OR CREMATORY: Southern
22d. LOCATION (City, town, or county) (State): Double Run Harford Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Charles E. Kurtz
ADDRESS: Jarrettsville Md
24a. REC'D BY REGISTRAR DATE: MAY 26 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5666

05672

CERTIFICATE OF DEATH

Reg. Dist. No. .....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY ~~Baltimore~~ Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air

LENGTH OF STAY (In this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 206 Penna. Ave.

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Md. COUNTY ~~Baltimore~~ Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air

STREET ADDRESS (If rural give location) 206 Penna. Ave.

3. NAME OF DECEASED (Type or Print) (First) CHARLES (Middle) Ryland (Last) STEVENS Jr.

4. DATE OF DEATH (Month) MAY (Day) 8 (Year) 1959

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
male	white	married	Sept. 6, 1932	26 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
I.B.M.operator	Glen L.Martin	Baltimore, Md.	U.S.A.

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Charles R. Stevens, Sr.	Laura Maria Bailey

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give wer or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
no	212-30-6217	Maria Harla Stevens, wife, above

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

592X IMMEDIATE CAUSE (A) Suffocation from Aspirated Vomitus — INTERVAL BETWEEN ONSET AND DEATH: 2 minutes

ANTECEDENT CAUSE(S) DUE TO

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) Chronic Glomerular Nephritis — 10 YEARS

DUE TO (C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY?
		YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, ferm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Dey) (Yeer) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/10, 1958, to 5/8, 1959, that I last saw the deceased alive on 4/16, 1959, and that death occurred at 5.40 P M, from the causes and on the date stated above.

SIGNATURE R.M.A. Barthel M.D. — ADDRESS (Street, city, town, state) Forest Hill Maryland — DATE SIGNED 5/9/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	5/12/59	Sacred Heart Cemetery	Baltimore, Md.

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
MAY 12 '59	Charles E. Schimunek	Charles E. Schimunek Funeral Home 3331 Brehms Lane

1

FOR STATE HEALTH DEPT.

Item 20 Film 242 5-14-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05673

5667 Item 9, Film G-242, 5-7-59 md

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre de Grace 1½ hrs
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol, give street address) Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Forest Hill
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First John Middle Israel Last Taylor

4. DATE OF DEATH Month MAY Day 2 Year 1959

5. SEX M

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Nov. 16-1879

9. AGE (In years last birthday) 80 79 Yrs.

IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) STREET, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Richard Taylor

14. MOTHER'S MAIDEN NAME Martha Scarff

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address Mildred T. Bailey Forest Hill, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture Skull — INTERVAL BETWEEN ONSET AND DEATH

812X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto accident, auto-pedestrian type

20c. TIME OF INJURY Hour 2 ~~a.m.~~ p. m. Month, Day, Year 5-2-1959

20d. INJURY OCCURRED While at work ☐ Not while at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —

20f. (City or town) Street (County) Harford (State) Md.

21. I certify that I took charge of the remoins described obove, held on Autapsy ☐, Inspection ☒, Inquiry ☐, ond in my opinion deoth resulted from: Natural couses ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE Gerald C Palmer M.D. CHIEF MEDICAL EXAMINER ☐ Bel Air, Md. DATE SIGNED 5-2-59

EXAMINER'S NAME (Type) Gerald C Palmer M.D. ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF MAY 5, 1959

22c. NAME OF CEMETERY OR CREMATORY Highland Cem.

22d. LOCATION (City, town, or county) STREET (State) MD.

23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins ADDRESS Delta, Pa.

24a. REC'D BY REGISTRAR DATE MAY 5 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

5668

05674 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Harford MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air
c. LENGTH OF STAY IN 1b
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Kalmia

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md b. COUNTY Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Bel Air
d. STREET ADDRESS 1 Kalmia
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) First Howard Middle A Last Thompson
4. DATE OF DEATH Month May Day 15 Year 1959
5. SEX M
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 23, 1917
9. AGE (In years last birthday) 41 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Sheriff
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Harford Co Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Elwood Thompson
14. MOTHER'S MAIDEN NAME Pearl Wells
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 218-09-8654
17. INFORMANT Mrs. Howard Thompson Address Bel Air, Md R.D.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion
420.1
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Gerald E Palmer M.D.
EXAMINER'S NAME (Type) Gerald E Palmer M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 5-15-59

22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF May 18, 1959 22c. NAME OF CEMETERY OR CREMATORY Harlington Cem. 22d. LOCATION (City, town, or county) (State) Harford Co., Md.

23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey ADDRESS Harlington, Md
24a. REC'D BY REGISTRAR DATE MAY 28 '59
24b. REGISTRAR'S SIGNATURE Carling E Hunt

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05675

5683 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Harford

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Aberdeen

c. LENGTH OF STAY IN 1b: 1 day

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: US Army Hospital Aberdeen Proving Ground, Maryland

d. STREET ADDRESS: Site B-4 Post Trailer Park

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First	Middle	Last	4. DATE OF DEATH	Month	Day	Year
	KAREN	MARIE	THYNG		May	4	1959

5. SEX	6. COLOR OR RACE	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min.
Female	Cau		3 May 1959	yrs.	1	

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
N/A	N/A	Maryland	USA

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Raymond Boyd Thyng	Vera Marie Disler

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT	Address
No	N/A	Father	Site B-4 Post Trailer Park Aberdeen, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH

776x

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May 3, 1959, to May 4, 1959, that I last saw the deceased alive on May 3, 1959, and that death occurred at 2:35 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: John Z Delp M.D.

ADDRESS (Street, city or town, state): USAH, APG, Md.

DATE SIGNED: 4 May 59

PHYSICIAN'S NAME (Type): JOHN Z DELP CAPT MC

22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
Burial	5/7/1959	Post Cemetery	Aberdeen Proving Gr. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: John G. Darring ADDRESS: Aberdeen Maryland

24a. REC'D BY REGISTRAR DATE: MAY 8 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Evans

2050192 XVI

VS A15 (4) 15M 10/57

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5684

05676

CERTIFICATE OF DEATH

Reg. Dist. No.....

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

1. PLACE OF DEATH

COUNTY Harford — MARYLAND

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Bel Air

LENGTH OF STAY (in this place): 45 yrs.

HOSPITAL OR INSTITUTION OR STREET ADDRESS: Churchville Road

2. USUAL RESIDENCE (HOME) OF DECEASED

STATE Maryland COUNTY Harford

CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rural - Bel Air

STREET ADDRESS (If rural give location): Churchville Road

3. NAME OF DECEASED (Type or Print): (First) Betty (Middle) Young (Last) Umbarger

4. DATE OF DEATH: (Month) May (Day) 28 (Year) 19 59

5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours	Min.
F	W	Widowed	August 27, 1875	83 yrs.				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Farming	Owner	Virginia	U.S.A.

13. FATHER'S NAME: John Young

14. MOTHER'S MAIDEN NAME: Francis Kirby

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)	(If Yes, give war or dates of service)	16. SOCIAL SECURITY NO.	17. INFORMANT & ADDRESS
No	—	219-36-1284	Joseph Y. Umbarger, Bel Air, Md.

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

			INTERVAL BETWEEN ONSET AND DEATH
422.1	IMMEDIATE CAUSE	(A) Cerebro-vascular accident (thrombosis)	24 hours
	ANTECEDENT CAUSE(S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO	(B) Arteriosclerotic Cardiovascular disease	1 year
	DUE TO	(C)	

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. URINARY Infection; Cardiac failure, compensated

19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES ☐ NO ☑

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.	21e. INJURY OCCURRED While at work ☐ Not while at work ☐	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 18, 19 59, to May 28, 19 59, that I last saw the deceased alive on May 28, 19 59, and that death occurred at 10:50 P.M., from the causes and on the date stated above.

SIGNATURE	ADDRESS (Street, city, town, state)	DATE SIGNED
Paul S. Stonesifer M.D.	115 Fulford Ave, Bel Air	5/28/59

23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
Burial	May 31, 1959	Mt. Zion Methodist Cemetery	Fountain Green, Maryland

24. REC'D BY REGISTRAR DATE	REGISTRAR'S SIGNATURE	25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS
JUN 2 '59	Arthur S. Evans	Joseph W. Foster W. Broadway + Williams St. Bel Air, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05677

5669 **CERTIFICATE OF DEATH**

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Harford. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Havre-de-Grace
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Harford Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md b. COUNTY: Harford
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 Aberdeen.
d. STREET ADDRESS: 114 Rigdon Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First MICHAEL Middle Lost VACIK

4. DATE OF DEATH: Month MAY Day 27 Year 1959

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 2-29-04
9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Fire-man.
10b. KIND OF BUSINESS OR INDUSTRY: A.P.G.
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Charles Vacik
14. MOTHER'S MAIDEN NAME: Mary Mikolaitik

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Pittsburgh Pa.
Novak Funeral Home - 3513 Brighton Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 30 Min
420.1
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. **I certify** that I attended the deceased from MAY 27, 1959, to MAY 27, 1959, that I last saw the deceased alive on MAY 27, 1959, and that death occurred at 4:30 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Philip W. Harman M.D. ADDRESS (Street, city or town, state): 307 Hickory DATE SIGNED: MAY 27, 59

PHYSICIAN'S NAME (Type): Philip W. Harman Bel Air, Md

22a. BURIAL, CREMATION, REMOVAL (Specify): Removal
22b. DATE THEREOF: 5/28/59
22c. NAME OF CEMETERY OR CREMATORY: Highwood Cemetery
22d. LOCATION (City, town, or county) (State): Pittsburg. Pennsylvania

23. FUNERAL DIRECTOR'S SIGNATURE: John F. Darring ADDRESS: Aberdeen. Maryland
24a. REC'D BY REGISTRAR DATE: JUN 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 shall be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05678

5670

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: HARFORD — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: HARFORD

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HAVRE DE GRACE
c. LENGTH OF STAY IN 1b: 9 DAYS

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 31 ABERDEEN

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: HARFORD MEMORIAL HOSP.

d. STREET ADDRESS: 305 D AUGUSTA

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John Middle: B Last: VETTORINO

4. DATE OF DEATH: Month: MAY Day: 22 Year: 19 59

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 3-1878

9. AGE (In years last birthday): 81 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Barber

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (State or foreign country): ITALY

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Anthony VETTORINO

14. MOTHER'S MAIDEN NAME: MARIA CAPITELLI

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: John R. Vettorino Address: 305 D. Augusta Pl. Aberdeen, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH: few minutes
DUE TO
757.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Surgery for Polycystic Disease of Kidney — 30 yrs
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from April 15, 19 57, to May 22, 19 59, that I last saw the deceased alive on May 21, 19 59, and that death occurred at 5 15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thos J Bryant M.D. ADDRESS (Street, city or town, state): 610 S Union Ave DATE SIGNED:

PHYSICIAN'S NAME (Type): Havre de Grace Md

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 5/26/59

22c. NAME OF CEMETERY OR CREMATORY: St. Johns

22d. LOCATION (City, town, or county) (State): Woodbury L.I. N.Y.

23. FUNERAL DIRECTOR'S SIGNATURE: VIGLIANTE FUNERAL HOME ADDRESS: BKLYN. N.Y. 406 ROGERS AVE

24a. REC'D BY REGISTRAR DATE: MAY 26 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55